FOCUS ON THE FISC

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FROM THE DESK OF THE FISCAL OFFICER

Your Legislative Fiscal Office is pleased to present the latest edition of Focus on the Fisc. We hope you enjoy it and encourage feedback. This issue provides an update of the OGB health plan options for the upcoming plan year, an update on the Alvarez & Marsal Contract, a description of the state treasury seed process and interfund borrowing concepts and an explanation of COLAs and the retirement Experience Account.

I would like to thank two members of our staff, Shawn Hotstream and Stephanie Blanchard for presenting 2 of the 5 comparative data reports at the 68th Annual Southern Legislative (SLC) Conference recently held in Little Rock, AR. Pictures from the presentations are of Stephanie presenting her Corrections Report and of Shawn presenting his Medicaid Report. The comparative data reports can be found on the LFO website at http://lfo.louisiana.gov/publications.

As has been stated before, this is your publication. If there is any way it can be made more useful including additional topics for research and inclusion in one of our upcoming publications, please contact us.

John D. Carpenter

FOCUS POINTS

OGB Update

J. Travis McIlwain, Gen. Govt. Section Director, mcilwait@legis.la.gov

The Legislative Fiscal Office (LFO) attended the OGB Policy & Planning Board meeting held on July 30, 2014. Along with multiple presentations from various vendors and the swearing in of new board members, OGB presented to the board the proposed health plan changes effective August 1, 2014 and January 1, 2015. A detailed explanation of the health plan changes and the fiscal impact of the changes are discussed below.

Since the FY 14 fiscal year's accounting cycle is not completed (August 15th is the deadline), the LFO has no additional OGB financial information to report to the committee relative to OGB's current fund balance. However, OGB's contract actuary provided a report to the OGB Policy & Planning Board that indicated the anticipated FY 14 ending year OGB fund balance to be approximately $218.4 M.

Note: Pages 9 and 10 of this document includes a listing of health insurance terms utilized throughout this document.

HEALTH PLAN CHANGES

In order to slow the current OGB monthly "burn rate" of spending $16.1 M more than monthly revenue collections, OGB is modifying the health plan options for all state employees (and participating school board employees) and anticipating these changes to result in $44.7 M in overall expenditure savings and

the prescription drug changes to result in an additional $69 M in expenditures savings all in FY 15.

The significant changes to the health plans include:

1. ***Significantly increasing the out-of-pocket maximum for all health plan options;***
2. ***Increasing deductibles for all health plan options;***
3. ***Increasing co-pays 100% for those proposed health plans with co-pays;***
4. ***Increasing the out-of-pocket maximum for the prescription drug benefit by $300 from $1,200 to $1,500 (20% increase);***
5. ***Subjecting the prescription drug benefit to a drug formulary with various drug categories that will result in an increased cost for preferred and brand name drugs and a decreased cost for generic drugs;***
6. ***Implementing other various prescription drug benefit changes including high compound management, over utilization management and the exclusion of medical foods;***
7. ***Requiring prior authorizations for certain medical procedures;***
8. ***Eliminating the out-of-network benefit for some health plan options, which could result in balanced billing for some OGB members depending upon the new health plan choice;***
9. ***Application of standard benefit limits (Blue Cross Blue Shield standard) for skilled nursing facilities, home health care services and hospice care services;***
10. ***Removing all vision coverage from the health plan options;***
11. ***Implementing the Live Better Louisiana wellness initiative;***
12. ***Decreasing premiums for the proposed HRA/HSA compared to the current Consumer Driven Health Savings Account (CDHSA) health plan option.***

The health plan and prescription drug plan policy changes listed above will shift more of the costs from the state (OGB Health Plan) to the OGB plan member and as mentioned above will save the state at least $44.7 M for health plan changes and at least $69 M for prescription drug plan changes in FY 15.

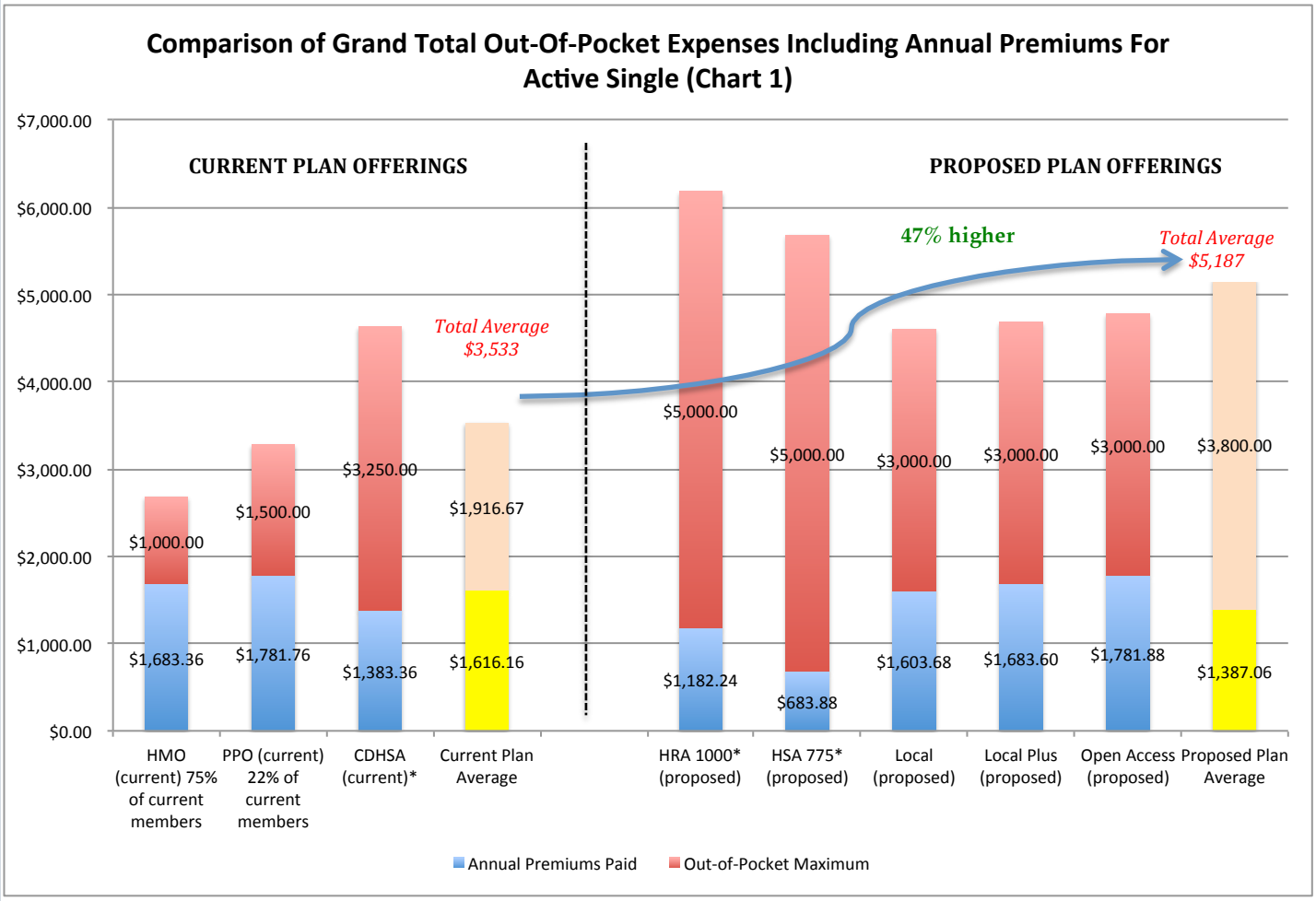
Along with premiums, the major costs incurred for medical services by an OGB plan member will be deductibles, co-payments and coinsurance. Table 1 below is a brief summary comparing the costs of the current major OGB health plan offerings to the proposed OGB health plan options for a Single Active Employee. Based upon Table 1, by adding and/or increasing deductibles, increasing the out-of-pocket maximum and increasing co-payments and coinsurance, the new health plan offerings will significantly reduce the cost to OGB, while the OGB member pays more for their medical services. As shown in Table 1, all new health plan options will have a deductible increase *(PPO plan currently has a $500 deductible for active single)*, an out-of-pocket maximum increase, a copay increase or incur the additional cost of having a deductible that currently does not exist for most OGB members. Of the total OGB population, 75% are currently enrolled in the HMO plan, which currently has a $0 deductible. Thus, the majority of OGB plan participants will be subject to a deductible and coinsurance whereas most are currently only subject to fixed co-pays.

TABLE 1

CURRENT OGB PLAN OFFERINGS				PROPOSED OGB PLAN OFFERINGS				
ACTIVE SINGLE	**PPO**	**HMO**	**CDHSA**	**HRA 1000**	**HSA 775**	**Local**	**Local Plus**	**Open Access**
Deductible*	$500	$0	$1,250	$2,000	$2,000	$500	$500	$1,000
Co-Pays	$0	$15/$25	$0	$0	$0	$25/$50	$25/$50	$0
Coinsurance	10%	$0	20%	20%	20%	$0	$0	10%
OOM (in-network)	$1,500	$1,000	$3,250	$5,000	$5,000	$3,000	$3,000	$3,000
OOM (out-of-network)	$3,500	$4,000	$3,250	$10,000	$10,000	N/A	N/A	$4,000
Out-of-Network Benefit	30%	30%	30%	40%	40%	N/A	N/A	30%

Note: *Based upon Table 1 above, it appears there is not much difference between the current CDHSA plan and the proposed HRA 1000 and HSA 775 health plan choices. However, as of the latest OGB enrollment information, there are approximately 350 total covered lives (223 OGB members) that are currently covered by the current CDHSA plan. This represents 0.15% of the total OGB member population. Since the majority of OGB's member population is either in the PPO Plan (22%) or HMO Plan (75%), comparing the current CDHSA health plan to the new health plans will not illustrate the complete fiscal impact to the OGB program and its membership.*

Chart 1 below compares the total out-of-pocket costs (true costs) including annual premiums paid (denoted in the blue bars below) and the out-of-maximum (total amount member must pay before health plan pays 100% denoted in the red bars below) for all current and proposed health plans. The average out-of-pocket costs for all proposed health plans are 47% higher than the average out-of-pocket costs of the current health plans (active single).



Based upon the new health plan offerings, the diagram on the next page is an illustration of how deductibles, coinsurance and out-of-pocket maximums work in relation to the new OGB health plan options that have deductibles and coinsurance. Due to the majority of OGB members being in the HMO plan without deductibles and coinsurance, these individuals will likely choose a plan with deductibles and coinsurance if the member wants a similar plan structure to the current HMO plan.

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DURING OGB PLAN YEAR (JANUARY 1 THROUGH DECEMBER 31)

How Deductibles, Coinsurance and Out-of-Pocket Maximums will work for the proposed HRA 1000, HAS 775 and Open Access Plan members.

STEP 1

Deductible

OGB member pays 100% of the healthcare costs up to the amount of deductible. Deductibles range from $500 to $8,000 depending upon health plan choice, plan type (single, family) and if the deductible applies to an in-network or out-of-network provider.

Note: If the OGB member has the HRA 1000 or HSA 775 plans, the resources in their HSA or HRA can be utilized to pay the deductibles and coinsurance.

Note: There are different out-of-pocket maximums and deducitibles for the out of network benefit portion of the health plan.

STEP 2

Coinsurance

After the deductible is met, the OGB member will pay coinsurance % up to the out-of-pocket maximum. Coinsurance costs range from 80/20 to 90/10 depending upon health plan choice. For example, 80/20 coinsurance means the OGB member will pay 20% of the contracted rate while the health plan pays 80%. Proposed out-of-pocket maximums range from $3,000 to $20,000 depending upon health plan choice and plan type (single, family).

Note: There are some health plan choices that do not have coinsurance and only have co-pays (Local/Local Plus)

Note: Along with the conisurance and co-pays, deductible payments go toward out-of-pocket maximum.

STEP 3

100% Paid by Health Insurance Plan

After the OGB member has met the out-of-pocket maximum (through deductible, co-pay & coinsurance), the health insurance plan will pay 100% of the medical costs.

Note: The pharmacy benefit has a separate out-of-pocket maximum, which is being increased by $300 from $1,200 to $1,500 effective August 1, 2014 for all active and Non-Medicare Retirees. The prescription drug out-of-pocket maximum for Medicare Retirees will be effective on January 1, 2015.

VARIOUS OGB SCENARIOS

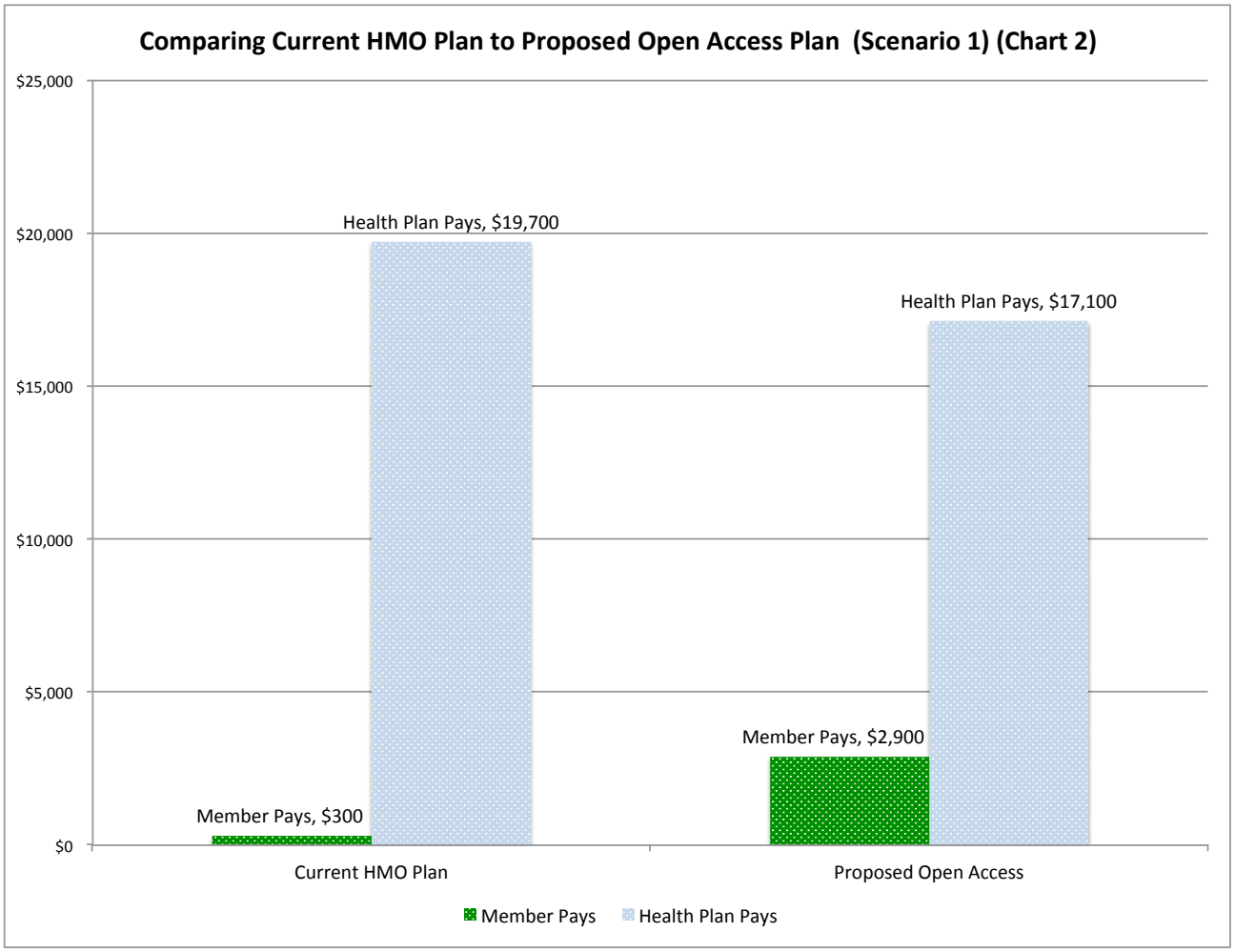
After reviewing the new health plan offerings presented to the board, the LFO has created a few scenarios to illustrate the cost saving potential to the OGB of the new health plan options compared to the existing plans. **These scenarios are based upon assumptions of the total contracted rate costs and assume all providers are in-network providers and facilities (hospitals) of the current Blue Cross Blue Shield Provider Network**.

Note: *For purposes of simplicity, all scenarios presented are for an active single member. A detailed and specific health plan comparison cannot be completed until the OGB/DOA releases the official proposed health plan documents of all five health plan options, which will not be made available until annual enrollment begins in October 2014. These scenarios are meant to assist in explaining the differences between the current plans and the proposed plans based upon OGB's presentation to the OGB board on July 30, 2014 and are in no way actuarially sound.*

***Scenario 1*:** At the beginning of the health plan year, an individual (active single) breaks his foot and has to have emergency surgery. Due to the complexity of the procedure, the individual is required to stay in the hospital for 3 days following surgery and requires the assistance of home health services upon hospital discharge. For this scenario, the total cost of these medical services is $20,000, which is broken down as follows:

- $17,000 – emergency room plus 3 days inpatient hospital bill
- $3,000 – home health bill
- $20,000 – Total

Based upon the proposed health plan offerings for this scenario, the OGB program will save significant medical claim expenditures. See Chart 2 below that compares the current HMO plan to the proposed Open Access heath plan option. ***Note:*** *These two plans were picked for comparison because the majority of OGB members (75%) have the HMO Plan and the Open Access Plan is the only proposed health plan option that is a traditional health plan that also has an out-of-network benefit like the current HMO plan.*



Based upon Chart 2 on the previous page, the OGB health plan will decrease its financial expenditures from paying 98% of the medical costs to paying 86% of the medical costs. In this scenario, this represents a 13% decrease in OGB health plan expenditures, but also represents a significant out-of-pocket increase for OGB plan members.

***Scenario 2*:** An individual (active single) visits an ENT (Specialist) on January 2, 2015 for treatment of a severe sinus infection. Due to January 2 being the second day of the new health plan year, the entire cost of the doctor visit (assuming $600 for an ENT visit with in-house lab work) will be borne by the OGB plan member (dependent upon health plan choice), which will result in expenditure savings to the overall OGB program. See Table 2 that compares scenario 2 costs under current health plan options to proposed health plan options.

$600 ENT DOCTOR VISIT ON JANUARY 2nd (SCENARIO 2) (TABLE 2)

	PPO	HMO	CDHSA**	HRA 1000**	HSA 775**	Local***	Local Plus***	Open Access
Deductible	$500	$0	$1,250	$2,000	$2,000	$500	$500	$1,000
Copays	$0	$25	$0	$0	$0	$50	$50	$0
Coinsurance*	90/10	$0	80/20	80/20	80/20	$0	$0	90/10
ENT Visit Costs	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**
Member Pays (deductibles, copays, coinsurance)*	($510)	($25)	($600)	($600)	($600)	($50)	($50)	($600)
Health Plan Pays	($90)	($575)	$0	$0	$0	($550)	($550)	$0

Coinsurance for the current **PPO plan is 90/10 once the deductible is met. Thus, under this scenario, a current PPO plan member would be responsible for paying the $500 deductible as well as 10% coinsurance of the remaining doctor visit cost, which equates to $10 in this scenario (10% of $100 = $10).*

***If the OGB member has the HSA 775 or HRA 1000, the $600 ENT visit could be funded with resources contained within the members' HSA or HRA account. This is currently the case for those members who have the CDHSA account. There is currently 0.15% of OGB's member population who has the CDHSA plan.*

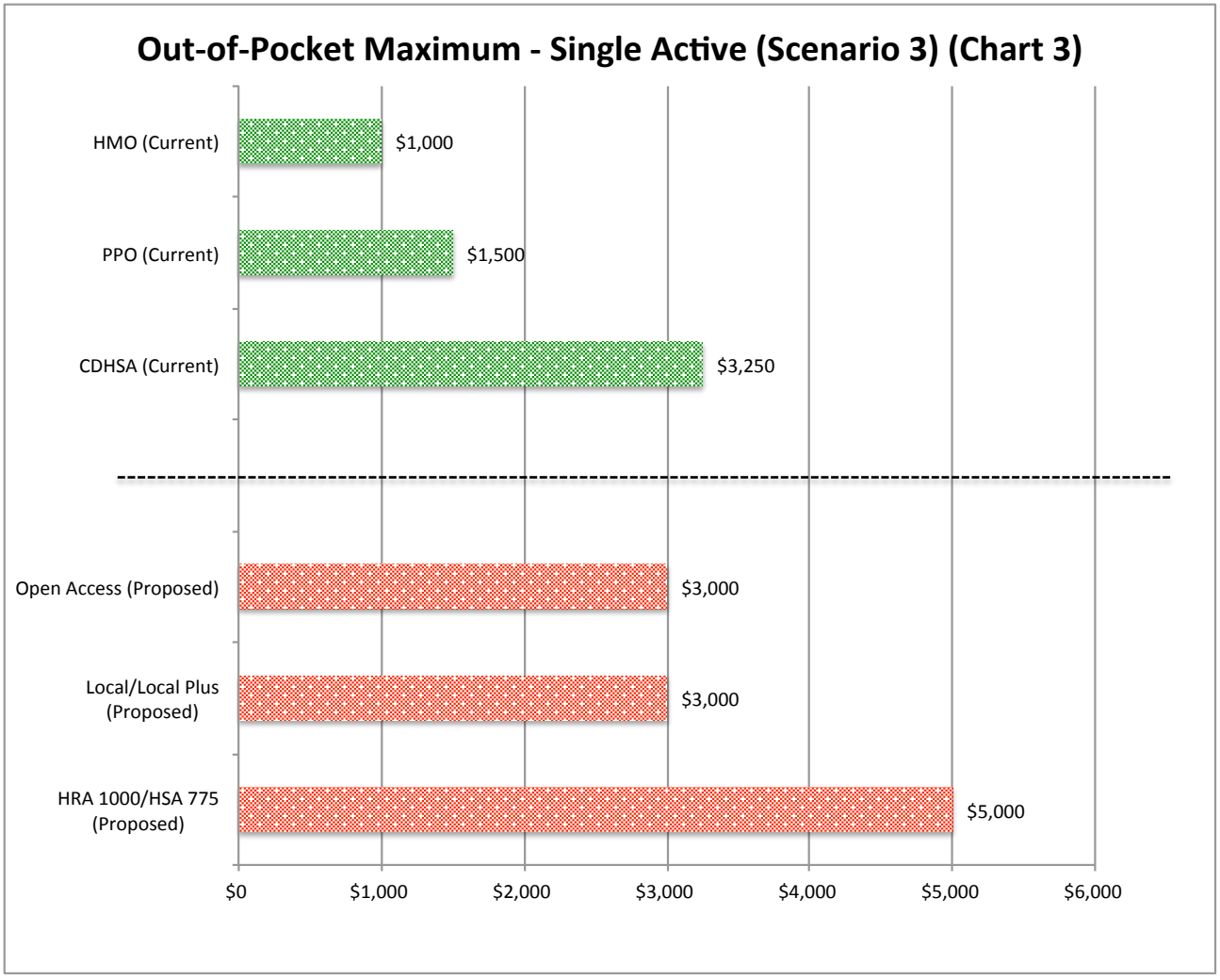
TABLE 3

Health Plans	Out-of-Network Benefit (Yes or No)	Out-of-Network Benefit
HMO Plan (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $4,000 (individual) or $12,000 (family)
PPO Plan (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $3,500 (individual) or $12,700 (family)
CD-HSA (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $3,250 (individual) or $11,000 (family)
Local/Local Plus (Proposed)	NO	No Out-of-Network Benefit
Open Access (Proposed)	YES	$1,000 deductible (single), $3,000 deductible (family), 30% coinsurance up to out-of-pocket maximum of $4,000 (individual) or $12,000 (family)
HRA 1,000/HSA 775 (Proposed)	YES	$4,000 deductible (single), $8,000 deductible (family), 40% coinsurance up to out-of-pocket maximum of $10,000 (individual) or $20,000 (family)

****These health plans only have an in-network benefit and no out-of-network benefit, which could result in the OGB member being **balanced billed** for medical services provided by providers outside the Blue Cross Blue Shield nationwide network for Local Plus plan option or the Blue Cross Blue Shield community network (Baton Rouge, Shreveport, New Orleans areas only) for the Local plan option. Balanced billing is the practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as the "reasonable and customary" amount. **If your health plan does not have an out-of-network benefit, the health plan member would be responsible for the entire medical service cost of the out of network provider. See Table 3 above for an out-of-network benefit comparison of the health plan choices compared to current plans.***

***Scenario 3*:** The same individual (active single) visits the ENT (Specialist) again on December 30, 2015 for treatment of a similar severe sinus infection. Due to December 30th being at the end of the health plan year, the $600 visit (with in-house lab work) could be completely covered 100% by the health plan, if the active single individual has met the out-of-pocket maximum of the health plan. See Chart 3 below that compares the out of pocket maximums for the current health plan options to the proposed health plan options before the plan covers 100% of an in-network providers' costs.

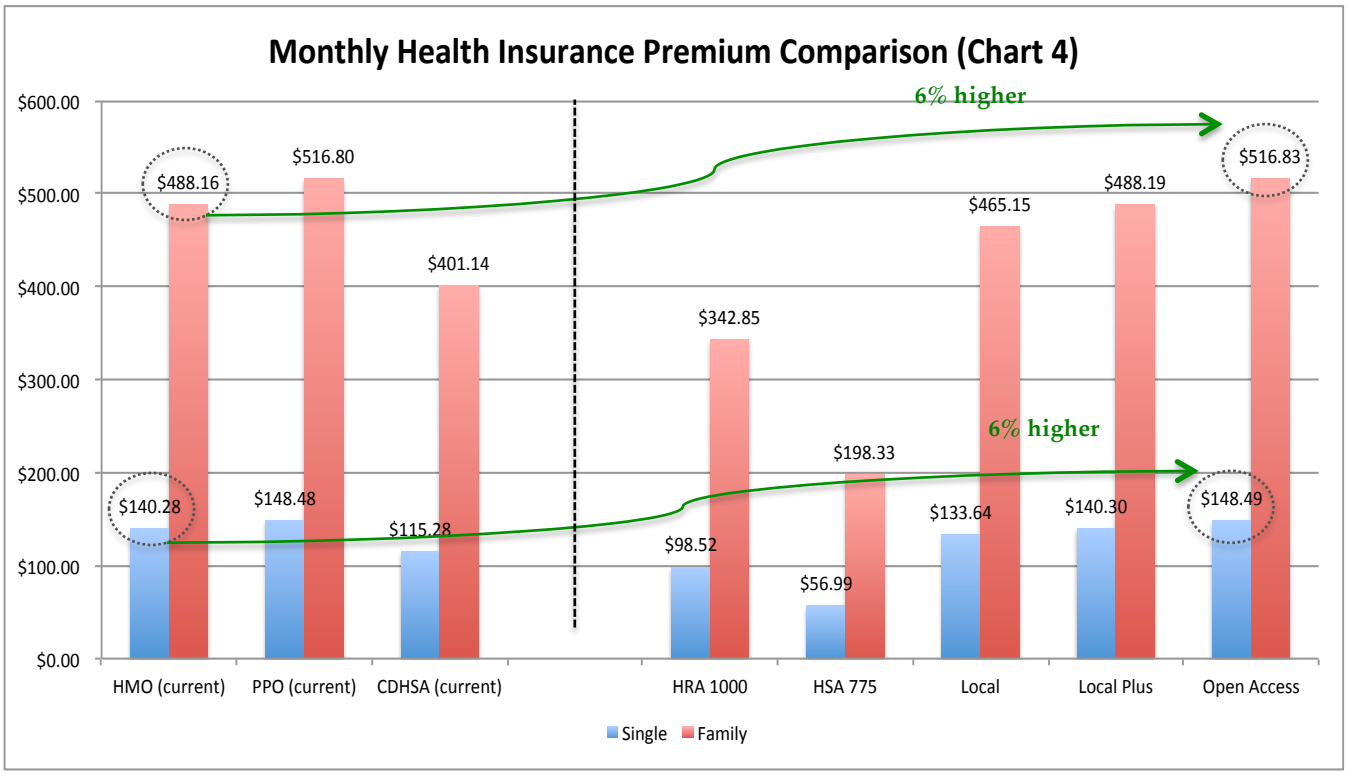
As illustrated in Chart 3 below, the $600 ENT visit at the end of the health plan year will be 100% covered if the out-of-pocket maximum is reached. **The out-of-pocket maximums for OGB plan members are significantly increased ranging from 54% increase (comparing current CDHSA to proposed HRA 1000/HSA 775) up to a 300% increase (comparing current HMO to proposed Open Access and Local Plus). This change will result in significant cost savings to OGB.**



HEALTH PREMIUMS

Other than the HRA 1000 and HSA 775 (premiums will be lower than current CDHSA), the health premiums for the new health plan options will remain unchanged for January 1, 2015. **However, due to the majority of the current OGB plan members (75%) being under the HMO Plan, those individuals that choose the Open Access Plan, which is the only traditional health plan with both an in-network and out-of-network benefit like the current HMO plan, will pay approximately 6% more in premiums beginning January 1, 2015. Due to the 5% premium increase that was effective July 1, 2014 these specific OGB members will be subject to a total premium increase of 11% in FY 15 (See Chart 4).** The Open Access plan premium mirrors the current PPO plan premium, which is currently 6% higher than the current HMO plan premium. OGB members who have the PPO plan and who pick the Open Access Plan would see no change in premium payments. See summary bullets and Chart 4 on the next page.

- Proposed HRA 1000 and HRA 775 premiums are significantly lower than the current CDHSA plan option;
- Proposed Local Plus premiums are the same as current HMO plan option;
- Proposed Open Access premiums are the same as current PPO plan option.



PRESCRIPTION DRUG CHANGES

Effective August 1, 2014, the prescription drug benefit changed for all current (active/non-Medicare retirees) OGB plan members. The prescription drug benefit will be subject to a tiered drug formulary and the out-of-pocket maximum will increase $300 from $1,200 to $1,500 (20% increase). The OGB anticipates these changes, along with other prescription drug changes, will result in overall OGB expenditure savings in the amount of $69 M in FY 15.

A drug formulary is a list of medications available to health plan members under the health plan's drug benefit. The formulary consists of 4 different drug categories: generic drug, preferred brand drugs, non-preferred brand drugs and specialty medications. Table 4 below is comparison of the prescription drug benefit prior to the August 1st changes and after the August 1st changes.

TABLE 4

Co-pay Before Out-Of-Pocket Is Met	Prior to August 1st	Change
Generic	50%, maximum $50 per month's supply	50%, maximum $30 per month's supply
Brand	50%, maximum $50 per month's supply	50%, maximum $55 per month's supply
Non-Preferred Brand	50%, maximum $50 per month's supply	65%, maximum $80 per month's supply
Specialty	50%, maximum $50	50%, maximum $80
Co-pay After Out-Of-Pocket Is Met	**Prior to August 1st**	**Change**
Generic	$0 per month's supply	No change
Brand	$15 per month's supply	$20 per month's supply
Non-Preferred Brand	$15 per month's supply	$40 per month's supply
Specialty	$15	$40

Based upon Table 4, the new prescription drug benefit changes incentivize OGB health plan members to purchase generic drugs as opposed to brand and/or non-preferred brand drugs.

Note: *The drug benefit changes effective August 1, 2014 will only impact Actives and non-Medicare retirees. The drug benefit changes will impact Medicare Retirees on January 1, 2015.*

Other prescription drug changes

In addition to implementing a tiered drug formulary and increasing the out-of-pocket maximum $300, OGB is implementing other prescription drug changes. OGB is anticipating the drug formulary changes to result in $43.2 M of FY 15 savings and the remaining $25.8 M in savings (for a total of $69 M) will come from the significant items listed below.

- *Clinical Utilization Management* – Require prior authorizations and quantity limits on prescription drugs ($10.8 M);
- *90 Day Fill Option* – For maintenance medications, 90-day prescriptions fills for 2.5 times the cost of your co-pay with a maximum of $75 ($9 M)
- *High Cost Compounds* – Require prior authorizations on high cost compounds over $400 ($3.4 M);
- *Over Utilization Management* – Identify OGB members receiving an equivalent greater than 120 mg/day of morphine or other narcotics being prescribed by multiple doctors and filled at multiple pharmacies ($1.2 M);
- *Acetaminophen Management* – Identify OGB members receiving more than the FDA recommended dose ($1.1 M);
- *Polypharmacy Management* – Identify OGB members receiving multiple prescriptions and determine if alternative options are available ($0.1 M);
- *Excluding Medical Foods* – The FDA does not have safety guidelines for these types of foods ($0.2 M).

LIVE BETTER LOUISIANA WELLNESS INITIATIVE

Although the costs for medical services will continue to increase, OGB is anticipating the Live Better Louisiana wellness initiative will assist in reducing future medical costs of the overall member population. This initiative encourages members to focus on preventive health including the use of the online personal health assessment tool and preventive onsite health checks. OGB anticipates this initiative will improve the OGB member future health outcomes that may result in reduced future medical expenditures of the overall program. Since the program's launch on May 30, 2014, there have been at least 280 members that have had a clinic check up of which 31% were identified as pre-hypertension and 14% were identified as pre-diabetic. OGB's remaining calendar year 2014 goal is to have 25% of the total member population screened.

HEALTH INSURANCE DEFINITIONS

Based upon research, the LFO has provided definitions of commonly used health insurance terms that are utilized throughout this document. The source of the prescription drug terms is from MedImpact's presentation to the OGB board on July 30, 2014. MedImpact is OGB's pharmacy benefit manager.

- ***Premium*** *– Amount of money a member pays monthly for health insurance.*
- ***Deductible*** *– Amount of money a member pays for eligible medical expenditures. After the deductible is met, the health plan pays 100% or the member shares the costs (coinsurance) with the health plan up to the out-of-pocket maximum (like the proposed OGB health plan options). The deductible is typically different for in-network and out-of-network providers. All new health plan options have different deductibles for in-network and out-of-network, excluding the Local/Local Plus health plans which have no out-of-network benefit at all.*
- ***Coinsurance*** *– Health cost sharing between the OGB member and the health plan. Cost share ranges included in the new OGB plan offerings range from 90/10 to 80/20, whereby the health plan pays either 90% or 80% of the medical service cost and the member pays the balance up to the out-of-pocket maximum.*
- ***Out-of-pocket Maximum*** *– The maximum amount of money an OGB member pays out-of-pocket for medical services in a health plan year. Under the OGB health plan offerings, co-pays, coinsurance and deductibles are all included in the out-of-pocket maximum calculation. The out-of-pocket maximum typically varies for in-network and out-of-network providers.*
- ***Health Savings Account (HSA)*** *– A savings account that is utilized in conjunction with a high deductible health insurance policy that allows an individual to save money tax-free in an account for medical expenses. Depending upon the employer policy, contributions are made to the account by the employer and employee*

and these funds can follow the employee.

- ***Health Reimbursement Arrangement (HRA)*** *– An employer funded account that reimburses employees for out-of-pocket medical expenses. HRAs are notional accounts and the funds cannot follow the employee. In addition, only the employer can contribute to the account.*
- ***Generic Drugs*** *– Identical to a brand name drug in dosage, strength, effectiveness and safety.*
- ***Preferred Brand Drugs*** *– Drugs that have been on the market and do not have a generic equivalent available.*
- ***Non-preferred Brand Drugs*** *– Higher-cost medications that have recently come on the prescription drug market.*
- ***Specialty Medications*** *– Brand or generic drugs that cost over $600 and typically treat specific diseases such as Cancer, Multiple Sclerosis and Rheumatoid Arthritis.*
- ***Balanced Billing*** *– The practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as "reasonable and customary" amount. If the health plan does not have an out-of-network benefit, the OGB member would be responsible for the entire medical costs of the out-of-network provider.*

In addition to the health and prescription drug changes, other topics of note related to OGB include the OGB Policy & Planning Board, the staff augmentation contract with Alvarez & Marsal (A&M) and the recently approved State Civil Service layoff plan.

OTHER OGB ISSUES

Office of Group Benefits Policy and Planning Board

Pursuant to R.S. 42:881, the OGB Policy & Planning Board shall review life and health benefit programs offered to eligible employees. In addition, the statute provides that the CEO shall submit any proposed changes to the life and health benefit programs to the board for review prior to the final adoption of the plan. The OGB board met on July 30, 2014 and the CEO presented to the OGB board the major health plan changes that will be effective on January 1, 2015 and the health plan changes that were effective August 1, 2014.

Although R.S. 42:802(B)(6) and R.S. 42:802(B)(7) authorize the OGB to establish premium rates and establish benefit plans under the direction of the commissioner of administration, it is unclear if the health plan and premium changes implemented by OGB in the middle of a plan year require official OGB board approval or if changing the health plan in the middle of the plan year is contradictory to the argument that the annual enrollment documents may be considered an annual contract between the health plan and the member. Also, pursuant to R.S. 42:881, the OGB shall submit a written report to the appropriate legislative oversight committees, including any comments and recommendations regarding modifications to proposed health plans. To date, this written report has not been completed. OGB's legislative oversight committees are the House Appropriations Committee and the Senate Finance Committee.

According to the Division of Administration (DOA), pursuant to federal law ***(26 CFR 54.9815-2715 – Summary of Benefits and Coverage and Uniform Glossary, paragraph (b) – Notice of Modification)*** if a group health plan makes any material modification, it must provide notice of the modification to enrollees no later than 60 days prior to the effective date change. OGB notified all plan members on June 3, 2014 of the August 1, 2014 health plan changes, which is within the 60-day requirement outlined in the federal law.

Note: *Prior to the July 30, 2014 OGB board meeting, the last OGB board meeting was held in February 2013. During that time frame, some of the significant changes that have been put in place include a health premium decrease (August 2013) and a health premium increase (July 2014).*

A&M Staff Augmentation Consulting Services Contract

On December 19, 2013, the State entered into a $4.2 M contract with Alvarez & Marsal (A&M) for consulting services relative to finding efficiencies in state government, which resulted in the production of the Governmental Efficiencies Management Support (GEMS) Report. The contract was amended on January 27, 2014 increasing the contract by $794,678 for staff augmentation support of OGB's *Acceleration of Benefits Transformation Initiative*. This contract amendment increased the total contract value to $5 M. The *Acceleration of Benefits Transformation* are the A&M recommended changes included in the GEMS Report

impacting the OGB including health plan and prescription drug changes as well as recommendations to completely reorganize the entire agency and implementing a wellness program that is anticipated to modify future health outcomes.

As was discussed by the LFO in the January 2014 edition of *Focus on the Fisc (Volume 2, Issue 7)*, the A&M consulting contract included provisions that allow for staff augmentation services. The contract provides for augmentation services to be provided on an hourly basis depending upon the labor category of the work order and project. In May 2014, the DOA and A&M amended the $5 M contract again to include 5 various state agency work orders for staff augmentation services that total $2.4 M of which $199,752 is associated with the OGB. This contract amendment essentially extended the original OGB work order from ending on April 18, 2014 to ending on June 30, 2014. Based upon the contract amendment, the hourly rates charged to the state for OGB staff augmentation services range from $198/hour to $446/hour. Upon approval of the A&M contract amendment of $199,752, the total maximum amount the state will pay to A&M for staff augmentation services will be $994,430.

The specific tasks included in the contract amendment to be provided by A&M for OGB include:

- Supporting leadership changes to OGB including supporting the search for CEO and COO;
- Assisting interim CEO and COO by supporting other OGB executive roles;
- Establishing & supporting a vendor-related strategic timeline and assist in any key vendor transitions;
- Supporting benefit open enrollment;
- Supporting, planning and execution for an agency reorganization and implementation of administrative efficiencies;
- Advising and implementing recommendations regarding change management and communication strategies and;
- Other staff support as requested regarding subject matter.

Layoff Plan Approved

The State Civil Service Commission officially approved the OGB layoff plan on July 28, 2014. According to documentation provided to the LFO by OGB, the layoff "is necessary because of a lack of work due to the change in function and structure of the OGB organization." The layoff plan will be effective September 1, 2014 and will impact 24 positions. The 24 positions being laid off impact the following OGB sections: Executive, Administration, Eligibility, Customer Service and Flexible Benefits. After the layoff, OGB will consist of 47 positions. The position reductions are associated with the overall reorganization of the agency, which is a portion of the OGB *Acceleration of Benefits Transformation*. For context, OGB's TO positions were

GENERAL GOVERNMENT

Alvarez & Marsal (A&M) Contract Update

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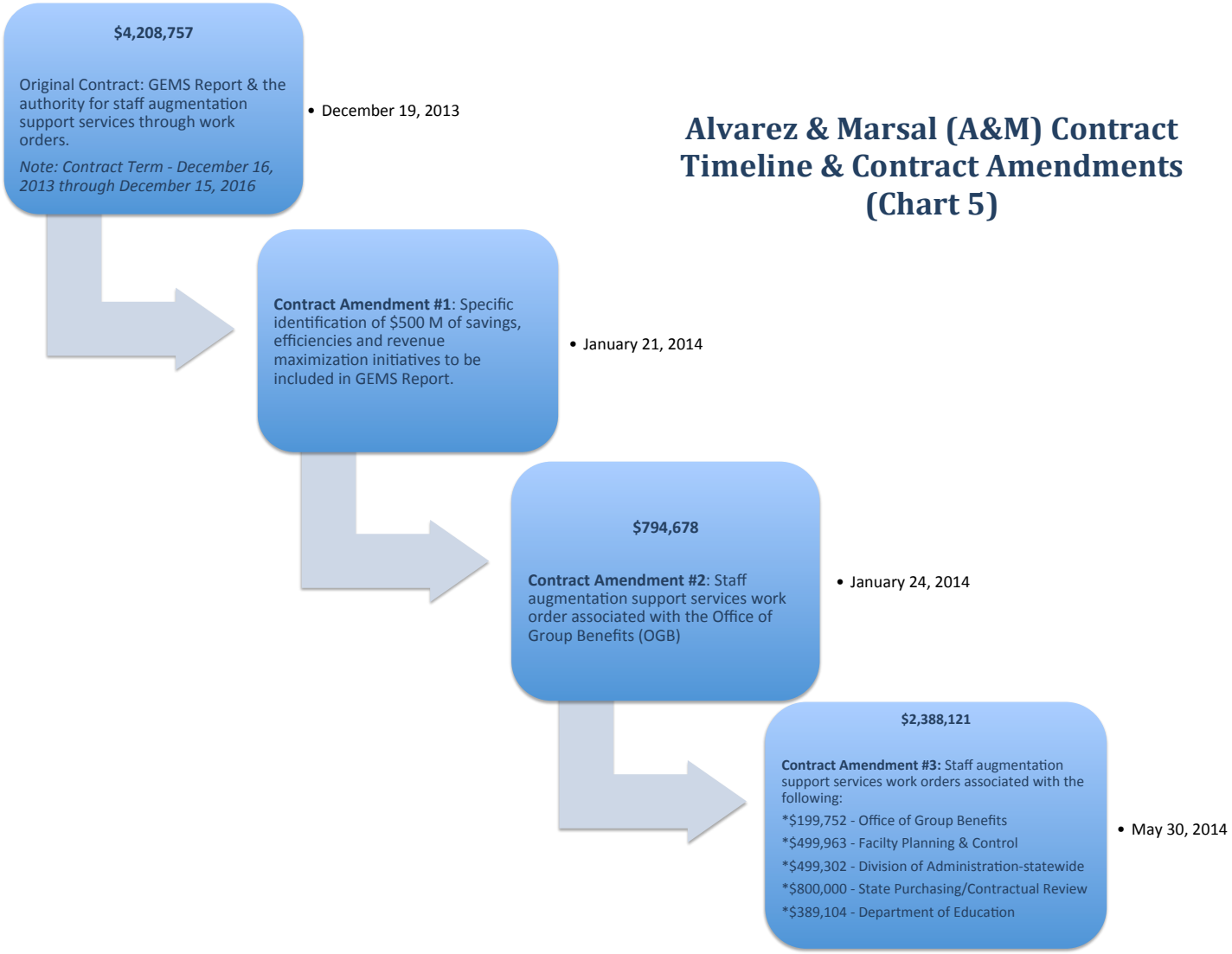
As was discussed by the LFO in the January 2014 edition of *Focus on the Fisc (Volume 2, Issue 7)*, the State entered into a $4,208,757 consulting services contract in December 2013 with the consulting firm Alvarez & Marsal (A&M) relative to efficiencies in state government. Since December 19, 2013 (start date), the total maximum value of the contract has increased $3.2 M, or 76%, and is now worth $7,391,556.

All of the increases are due to staff augmentation work orders. Although the original due dates for the various deliverables ranged from January 2014 to April 2014, the contract term actually ends on December 15, 2016. This is due to provisions in the contract that allow A&M to provide staff augmentation services to state agencies for implementing any recommendations presented in the Governmental Efficiencies Management Support (GEMS) Report. The specific work orders that resulted in the $3.2 M increase along with a timeline of events are shown Chart 5 on the next page. As the contract end date being December 15, 2016, there may be additional work orders approved that could further increase the maximum value in excess of $7.4 M. ***Note: Work Order #5 of the A&M staff augmentation for the DOE related to the MFP student enrollment counts seems to be duplicative of the work requested of the Legislative Auditor pursuant to HCR 112 that passed during the 2014 R.S.***

Alvarez & Marsal (A&M) Contract Timeline & Contract Amendments (Chart 5)



State Treasury Seeds & Interfund Borrowing

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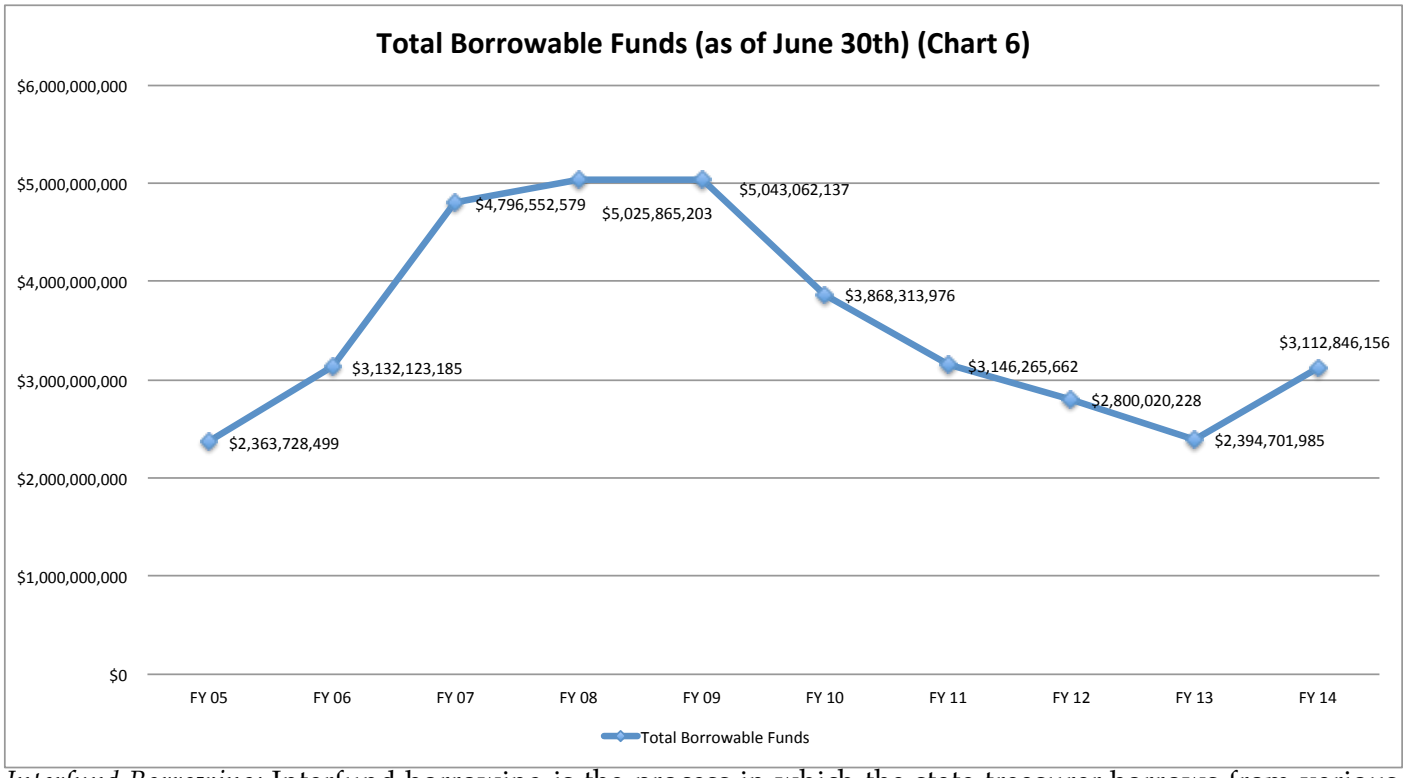
Pursuant to R.S. 39:71(D), upon approval of the commissioner of administration and concurrence of the state treasurer, a cash advance or seed may be granted to a requesting state agency. Typically treasury seeds are designed to provide operating capital to a state agency until an anticipated revenue source is actually collected. For example, a state agency whose primary source of operation is from a statutorily dedicated fund that only collects revenues one time during a fiscal year needs resources to operate until that fund's revenues are actually collected. Thus, the commissioner of administration in concurrence with the state treasurer can approve a seed until those statutorily dedicated revenues are actually collected. Once collected, the agency will utilize these collections to repay the state treasury for the total amount of seed resources expended. State treasury seeds are basically short-term loans that must be repaid prior to the close of the fiscal year. However, in some instances, the state treasury seed is being paid in full by reseeding it in the next fiscal year. The state is essentially repaying the short-term loan with another short-term loan and the fund's short-term debt is being pushed to the next fiscal year. An example of this situation is the Oil Spill Contingency Fund. Instead of having the remainder of the same fiscal year in which the seed was requested to repay a seed, DPS has had multiple fiscal years to repay the seed (FY 12, FY 13 & FY 14) and will continue to have multiple fiscal years until such time as BP settlement funds are received. Table 5 is a listing of significant FY 13 treasury seeds paid back with a portion of reseeded FY 14 proceeds.

Significant FY 14 "Reseeds" Utilized to Pay FY 13 Seed (TABLE 5)

Agency	Amount
Bayou Corne (DNR)	$8,000,000
Oil Spill Contingency Fund (DPS)	$24,400,106
TOPS Fund	$5,995,170
Public Service Commission	$2,000,000
TOTAL	**$40,395,276**

Based upon information provided to the Legislative Fiscal Office by the State Treasury and utilizing the Oil Spill Contingency Fund as an example, the fund's seed has been paid in full each fiscal year by reseeding. Although the agency's official documentation indicates the $0.02 per barrel fee (approximately $8 M annually collected) will be utilized to repay the seed, the administration and DPS contend these loans will actually be paid in full upon settlement resolution. ***Thus, instead of using SGF direct appropriation to fund these items and then utilize any legal settlement proceeds to reimburse those prior SGF direct expenditures, the state is currently using SGF/interfund borrowing cash to fund these expenditures via the state treasury seed process***. As long as the state maintains healthy borrowable cash on hand, the reseeding process will continue to work. However, to the extent the borrowable reserves significantly decrease, supporting these expenditures and/or financing additional seeds of this nature with annual short-term loans could be problematic. See Chart 6 below for a 10-year history of the total borrowable fund resources as of June 30th of each fiscal year. Although the FY 14 borrowables increase from FY 13 borrowables, the state's borrowable funds have decreased in four of the last five fiscal years. *On page 14 of this edition of Focus on the Fisc are illustrations of how a traditional state treasury seed works and how a reseed treasury seed is working per information provided by State Treasury.*

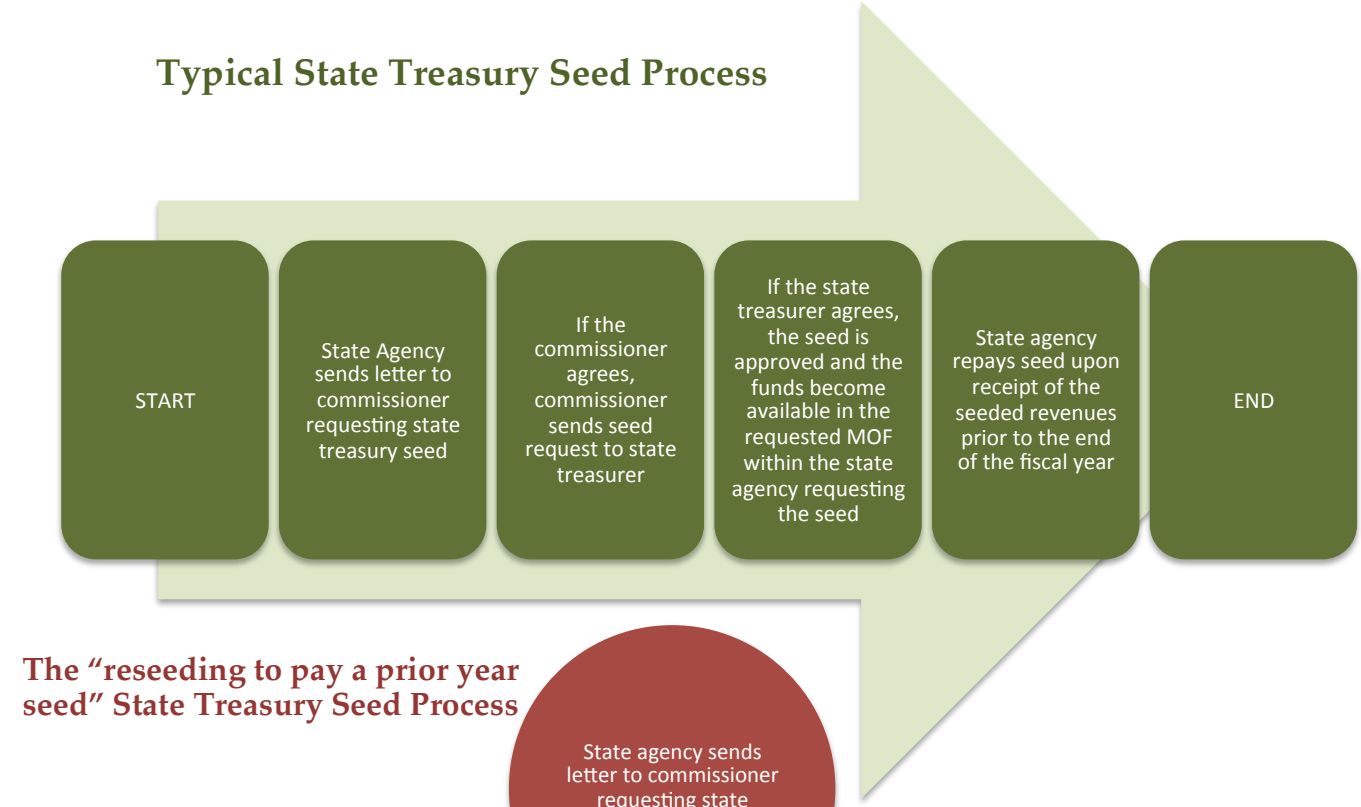


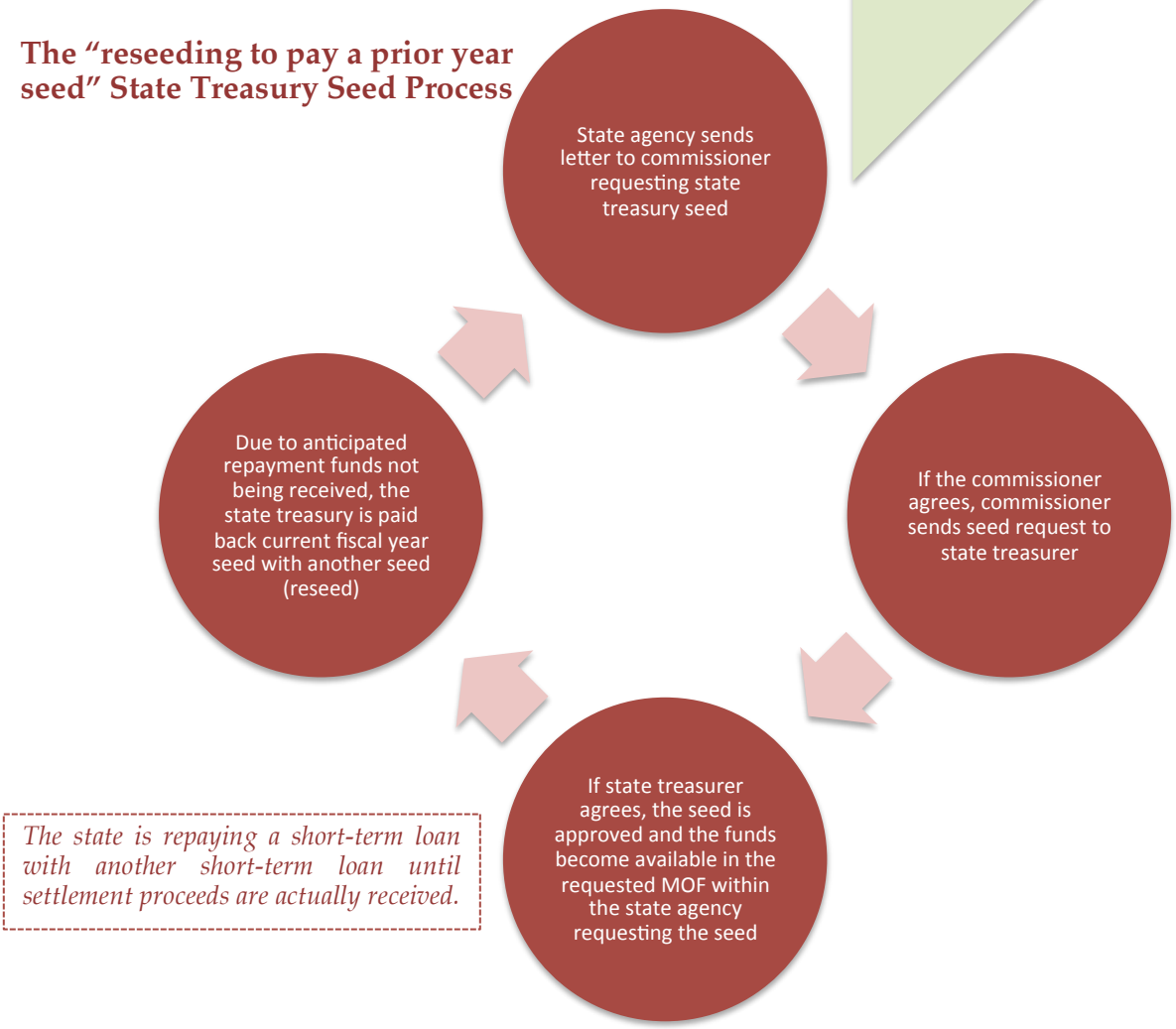
Interfund Borrowing: Interfund borrowing is the process in which the state treasurer borrows from various eligible statutorily dedicated funds in order to support the cash flow needs of the SGF during a fiscal year. R.S. 49:308.4 authorizes the state treasurer to interfund borrow from any eligible fund to make payments from the SGF. As has been previously discussed, during a fiscal year there are times when SGF expenditures may exceed SGF cash on hand. When this occurs, the state enters into interfund borrowing until SGF collections are received that can support SGF expenditures. This is a typical occurrence for most governmental entities (state & local) that have irregular expenditure and revenue patterns.

Similar to a Bank: Interfund borrowing and the state treasury seed process can easily be compared to how a traditional bank operates. For example, even though an individual has $100 in his/her checking account, the bank is actually using these funds through the loan process for other customers. The bank does not necessarily have to provide that $100 to the customer until that customer makes a draw against his/her account. This is similar to the interfund borrowing and state treasury seed process. Even though a statutorily dedicated fund may have $1 M of cash on hand registered in the state's accounting system, that cash is either being invested, loaned through the state treasury seed process, or is borrowed by the SGF during a fiscal year (interfund borrowing). The $1 M balance does not necessarily have to materialize until expenditures have been drawn by a state agency. This process works because the state currently has approximately $3 B in borrowable cash from various eligible statutorily dedicated funds (See Table 5 on previous page). ***Note:*** *A minimal fiscal impact resulting from interfund borrowing and state treasury seeds is that*

it reduces the investable pool of resources contained in the state treasury. Thus, utilizing these cash items for interfund borrowing and short-term loans purposes decreases the amount of interest earned by the state.

Diagrams of State Treasury Seed Process: Below are diagrams of the typical state treasury seed process (green) and the Oil Spill Contingency Fund state treasury seed process (red). Notice that the typical state treasury process has an ending, while the reseeding state treasury seed process does not.





The state is repaying a short-term loan with another short-term loan until settlement proceeds are actually received.

Experience Account Funding and Cost of Living Adjustments (COLAs)

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With the enactment of Act 399 of the 2014 Regular Legislative Session, the calculation for automatic gain sharing rules were changed for all four state retirement systems. Automatic gain sharing is the transfer of investment gains earned by the retirement system to the system's Experience Account. Each system has a different calculation for how much is to be transferred to the Experience Account. As a result of Act 399, the amount of investment gains transferred to the Experience Account will be less and more of the investment gains will be used for payment towards the existing Unfunded Accrued Liability (UAL). According to the actuarial note for Act 399, employer contributions will be decreased by approximately $5 B over the next 30 years as a result of more investment returns being used to pay down the UAL.

Current Experience Account Funding Method: Each system has a different gain sharing calculation that funds the system's Experience Account if the system meets the assumed rate of return. The Experience Account is the account used to fund COLAs for retirees. Once certain hurdles are met for each system, 50% of investment gains are transferred to each system's Experience Account and the remaining 50% is used to pay down the UAL. For example, when the Louisiana State Employees' Retirement System (LASERS) meets its assumed rate of return, 50% of investment gains in excess of $100 M are deposited into the Experience Account. In 2013, once the funding hurdles were cleared, the remaining investment gain was $391.2 M, which would result in a transfer of $195.6 M into the Experience Account and $195.6 M paid to the UAL.

New Experience Account Funding Method: The significant change for the Experience Account is the amount that can be transferred into the account. Any amount that is not transferred into the Experience Account that previously would have been, will be applied to the UAL.

Once the investment gains are reduced to pay the debt of the system, 50% is available for the Experience Account. Under the previous calculation, half of the $391.2 M went to the Experience Account ($195.6 M) and the other 50% ($195.6 M) was used to reduce the UAL. Table 6 and the discussion that follows provide an illustration of how the previous transfer worked and how the new transfer will work:

TABLE 6

	Previous Calculation	Current Calculation
50% for Experience Account	$195,623,963	$195,623,963
Cost of 1.5% COLA	($97,481,233)	($97,481,233)
Remaining Investment Gain	$98,142,730	$0
Investment Gain Paid to UAL	$0	$98,142,730

Under the new calculation, an additional $98.1 M that would have been in the Experience Account would now be used to reduce the UAL. As a result of this new calculation a total of $293.7 M (195.6 M 50% investment gain + $98.1 M remaining from Experience Account transfer) would now be paid towards the UAL instead of only $195.6 M in years past. ***Note:*** *Table 6 above is purely for illustrative purposes to show how the new gain sharing mechanism will work. It has not been calculated by an actuary.*

The amount transferred into the Experience Account will vary depending on the funded ratio of the system. Table 7 below reflects the impact on COLAs as the funded ratio increases.

TABLE 7

Funded Ratio	Transfer Amount to Experience Account (EA)
80% or more	Difference of the cost of a 3% COLA and amount in the EA
75% - 79.9%	Difference of the cost of a 2.5% COLA and amount in the EA
65% - 74.9%	Difference of the cost of a 2% COLA and amount in the EA
55% - 64.9%	Difference of the cost of a 1.5% COLA and amount in the EA
Less than 55%	No transfer can occur

Cost of Living Adjustments (COLAs) Granted: After the 2014 Regular Legislative Session, four bills allowed qualified retirees within the four state systems to receive COLAs. The COLAs were granted to retirees that were retired for at least 1 year and 60 years old, disability retirees that were retired for at least 1 year regardless of age, beneficiaries of retirees who would have met the applicable criteria to receive the increase if they had survived, and non-retiree beneficiaries who have been receiving a benefit for at least one year and whose benefits originate from service of deceased members who would have attained age sixty. All retirees were granted a 1.5% increase, however the maximum amount the increase was based on varied by system. All COLA costs and retirees affected are detailed in Table 8 below:

TABLE 8

System	COLA Cost	Retirees Affected	Maximum Benefit Amount
STPOL	$4.5 M	1,069	$94,313
STPOL*	$5.0 M	720	$94,313
LASERS	$97.4 M	36,969	$96,931
LSERS	$15.8 M	11,930	$94,313
TRSL	$185.1 M	61,074	$93,755

** STPOL retirees and beneficiaries over the age of 65 received a supplemental COLA of 2% on a benefit up to $94,313.* ***Note:*** *The costs and affected members were taken from the actuarial note on the respective Acts.*